From: DOH HSQA CN Rulemaking
To: Kido, Jeni H (DOH); Kolln, Jules (DOH)
Subject: FW: PCI Rulemaking Guiding Principles
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From: HealthFac <HealthFac@healthfacilitiesplanning.com>
Sent: Friday, July 19, 2024 11:37 AM
To: DOH HSQA CN Rulemaking <CNRulemaking@doh.wa.gov>
Subject: PCI Rulemaking Guiding Principles

External Email

Good morning CN Program, per the recent Workshop 2 follow up email, enclosed please find HFPD's preliminary thinking about guiding principles. Thanks for adding this opportunity.

1. Basic health planning principles, including adjustments for in and out migration, reasonable travel times for care and choice (in Planning Areas above a certain population threshold) should be considered in both definitions of planning areas and projection methodologies.

2. Equity, access, and quality should always be at the forefront.

3. A finding of no numeric need should not be the "end all/be all". Hospitals should be able to put forth applications absent numeric need, and the Program should have the ability to approve them. The burden is on the applicant to demonstrate inequities, cardiac morbidity and mortality rates, disease burden, social determinants, history of 24/7 PCI and historical case volumes (in-house and referrals)

4. Tiebreaker should not be furthest distance, especially when data on a hospital's actual catchment area (where 75-80% of its patient reside) demonstrates that there are less than 200 annual PCI cases in its market.

5. Data used must be publicly available and verifiable.

6. PCIs should be defined by ICD-10 and CPT. All PCIs should count—including PCIs performed (and viewable in datasets), but not the primary reason for hospitalization at discharge). Also, some inpatients have more than 1 PCI during a stay, each PCI should be counted.

7. If consideration is to be given to PCIs being performed in ASCs, a set of standards which ASCs must meet, should be created, including charity care and payer, and a determination as to whether the ASC must meet the 200 volume standard (since they will not be performing

emergency cases should be set. Importantly, the impact on hospitals in the Planning Area performing PCI should be quantified and evaluated by CN during its review.

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